NEW PATIENT REGISTRATION

Registracion del Paciente

Date_____ **E-mail**_____
Direccion Electronica

Home #_____ **Work #**_____**Cell #**_____
Telefono del Hogar *Telefono del Trabajo* *Telefono Celular*

First Name_____ **Middle Initial**_____**Last Name**_____
Primer Nombre *Segundo Nombre* *Apellido*

Home Address_____ **City/State/Zip**_____
Direccion del Hogar *Ciudad/ Estado/ Codigo Postal*

Social Security #_____ **Date of Birth**_____ **Marital Status**_____
Numero de Seguro Social *Fecha de Nacimiento* *Estado Civil*

Employer_____**Occupation**_____
Empleador *Ocupacion*

Primary Language_____**Referred by**_____
Idioma Primario *Referido por*

Spouse/Guarantor/Responsible Party/Emergency Contact

(Esposo (a)/Persona Responsable)

Name_____ **Relationship**_____ **Date of Birth**_____
Nombre *Relacion al paciente* *Fecha de Nacimiento*

Social Security#_____ **E-mail**_____
Numero de Seguro Social *Direccion Electronica*

Home #_____ **Work #**_____**Cell #**_____
Telefono del Hogar *Telefono del Trabajo* *Telefono Celular*

Employer_____ **Occupation**_____
Empleador *Ocupacion*

Insurance Information: Please provide your insurance card and photo I.D. to the receptionist

All fees are payable at the time services are rendered. We accept Visa and Master Card.
Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos Visa y Master Card

FINANCIAL RESPONSIBILITY AGREEMENT/CONVENIO DE RESPONSIBILIDAD FINANCIAL

The undersigned agrees, whether he/she signs as parent, spouse, guarantor, guardian, or patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, I authorize the attorney to obtain my credit report; and the undersigned shall pay reasonable attorney's fees and collection expenses.

El suscrito/a conviene que al firmar como padre, esposo/a, fiador, guardian o paciente, asume la responsabilidad y obligacion por cualquier balance pendiente que derive a causa de tratamiento medico a dicho paciente. En caso de que la cuenta fuese referida a un abogado, yo autorizo al abogado que obtenga mi reporte de crédito; y el suscrito/a pagara dichas cuentas legales y asumira costos de coleccion.

Signature_____Date_____

PHYSICIAN'S RELEASE AND ASSIGMENT

I hereby authorize payment directly to the physician of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or the other third party payer, for services rendered by the physician. I understand that I am financially responsible to the physician for any and all charges that the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el pago directamente al medico todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho a recibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compañia de seguro para procesar mi reclamacion. Yo entiendo que soy responsable por todos los cargos no cubiertos bajo mi seguro medico.

Malpractice Statement

We have elected not to carry Medical Malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgments up to the minimum amounts pursuant to S.458.320 (5) (g).Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is pursuant to Florida Law.

Hemos elegido no llevar seguro de negligencia medica, o demostrar de otra manera responsabilidad financiera. Sin embargo, acordamos satisfacer cualquier juicio adverso hasta las cantidades minimas conforme a S.458.320 (laley 5) (g). la ley de la Florida impone penas contra los medicos no-asegurados que no pueden satisfacer los juicios adversos que se presentan por demanda de negligencia medica. Este aviso esta conforme a la ley de la Florida.

Notice of Privacy Practices

Physicians have always protected the confidentiality of health information and have refused to reveal such information. Today, state and federal laws are also attempting to ensure the confidentiality of this sensitive information. The federal government recently published regulations designed to protect the privacy of your health information. This "privacy rule" protects health information that is maintained by physicians, hospitals and other health care providers and plans. The new regulation, effective April 14, 2003, protects virtually all patients, regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to a hospital, fill a prescription or send a claim to a health plan, those professionals will need to consider the privacy rule. All health information, including paper records, oral communication and electronic formats (such as E-mail and electronic claim filing) are protected by the privacy rule. The Notice of Privacy Practices*,* which is available in our waiting room, contains information about how your confidential health information is protected by this office and describes how you can exercise your rights with regard to your health information. The privacy rule provides you certain rights, such as the right to have access to your medical records; however, because there are exceptions to these rights, they are not absolute. We encourage you to read the *Notice of Privacy Practices* as your signed consent is required.
Please let us know if you have any questions about the *Notice of Privacy Practices.* To contact our Privacy Officer, call (305) 665-9644.

ACKNOWLEDGMENT

I have read and understand the Physician's release and assignment
I have read and understand the Malpractice Statement
I have read and understand the Notice of Privacy Practices

Signature _____Date_____

YEARLY APPPOINTMENT REMINDER

****your appointment reminder will be emailed and texted****

If this is NOT OK please advise front desk

DATE:_____
NAME:_____

DATE OF BIRTH:_____
EMAIL:_____

PAP SMEAR RESULTS

****your pap result will be emailed and texted****

If this is NOT OK please advise front desk

DATE:_____
NAME:_____
DATE OF BIRTH:_____
EMAIL:_____